Between the body and the politic

Reading recommendations on epidemics, international law, and history – Part II

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Herlihy writes of the Black Death, “the plague caused divisions between the healthy and the sick, those in the cultural mainstream and those in the margins… and between the mass of society and its cultural leaders”. Those in the margins of society included strangers, travelers, beggars, lepers, Jews, the poor… the list goes on. Towns routinely closed their gates to all outsiders. During the plague of the 1890s, the medical community in Argentina ascribed the outbreak of plague in Paraguay to the “backwardness” of a nation they considered “marginal to civilization”, writes Myron Echenberg in *Plague Ports.* In Cape Town, the threat of plague was used to further entrench residential segregation, and in Pacific ports accounts of racism towards persons of Asian descent were common. Indeed, as Paul Slack comments in his introduction to *Epidemics and Ideas*, this is the one common feature of almost all epidemics:

> “[C]arriers of disease were identified and scapegoats stigmatized: foreigners most often, as in Renaissance Italy and modern Hawaii, since epidemic disease came from outside, but also inferiors, carriers of pollution of several kinds, among whom disease had its local roots – untouchables in India and ex-slaves in Africa, or Jews at the time of the Black Death. For their part, inferiors themselves thought epidemics the consequence of plots by external enemies, or governors and elites, to ‘poison’ the poor.” (4)

Ziegler’s account of the persecution of Jewish communities during the Black Death also mentions persecution of Arabian people in Spain, English people in France, and lepers in England. The existential invisible threat of disease tends to make us close up reflexively and turn inward. It divides us precisely when coordination and cooperation is most needed.

Of course, this is counter-productive and self-destructive. When the plague arrived at Messina in 1347, the city’s residents knew it was too late to save themselves, and yet insisted on retribution towards those who had brought the disease – in effect spreading it all across the Mediterranean. Ziegler tells the story of how a Tartar army, upon discovering plague amongst their ranks, catapulted the corpses of their dead over the walls of the city they were laying siege to. In India in the 1890s, when British colonial authorities heavy-handedly and indiscriminately flooded houses with disinfectant, they spread the rats carrying the disease across neighborhoods and cities (see Chandavarkar). During the Black Death, Paul Clement VI issued a papal bull discrediting the rumors that Jews were spreading the disease, in an attempt to halt the persecution. He pointed out the obvious: the plague is spreading in areas without Jewish communities, and Jewish communities are *also* victims of the plague.

His arguments fell on deaf ears: in Basel, for instance, Jews were penned up in wooden buildings and burned alive. Ziegler points out that there were economic reasons for wanting Jewish communities out of the way.

Indeed, the very urgency of infectious diseases makes them powerful tools to be yielded in self-interest, often *against* the common purpose of defeating the epidemic. Valeska Huber describes how Britain stonewalled the creation of an International Agency of Notification for the reporting and tracking of infectious diseases in 1885. The reason was political self-interest: it would have hampered their control over the Suez Canal. Her account of the International Sanitary Conferences (1851-1894) details how, despite general recognition of the common global threat of cholera, the conferences were heavily skewed towards European interests. A stark example can be seen in how Egypt is described in these negotiations between colonial powers as a "natural barrier to the invasion of the epidemic from the tropics".

Herein lies the close interplay between international relations, law, and infectious diseases. Whatever the delineation of the "we", it is almost certain to be insufficient and self-defeating, unless it is global. Epidemics don't recognize borders. And more than this: epidemics closely follow our own traversing of borders – spreading along trade routes and the patterns of interactions among peoples. The history of quarantine and western public health law is usually traced back to Ragusa (modern-day Dubrovnik) and Venice – for obvious reasons: these were hubs for travel and trade, venues for international interactions. Eugenia Tognotti details the close historical connection between infectious disease, trade, and legal-institutional responses such as quarantine and the establishments of bills of health.

It is not only trade. As John Henderson points out in *Florence under Siege: Surviving Plague in an Early Modern City*, there is more to the connection between war and combating disease than mere poetic license: armies literally carried endemic and epidemic diseases with them. This was perhaps nowhere more apparent than in the Americas: McNeill estimates that, within 50 years of Cortez's arrival, the indigenous population had been reduced by 90% – in large part due to the spread of infectious disease. Infectious diseases are not only a consequence of the globalized world, in other words, they shape it. Elizabeth Kolbert describes this in her article in her New Yorker (reviewing Loomis's *Epidemics* and Snowden's *Epidemics and Society*): the decline of Justinian's Rome, the lead-up to the Russian Revolution, large demographic shifts across the globe. Ziegler links the Black Death to the acceleration of the 1381 peasants' revolt in England and the Reformation as a response to erosion of public trust in the Church. Much has been made of the Malthusian effects of the Black Death, including its impact on European labor mobility and increased productivity.

The impact of epidemics spread even beyond the reach of bacteria and viruses. Even if a particular community could avoid the health risks of the disease, the economic impact of epidemics has always been mobile. This is a lesson we need no reminding of today. Ziegler relates the records of loans made in the French town of Perpignan when the plague arrived there in April 1348. In February of that year, there had been 25 loans, in March, 32. In the first 11 days of April, there were eight;

three in the rest of the month, and none until August 12th. In a short and fascinating read on the impact of the outbreak of plague in seventeenth-century Tuscany – *Faith, Reason, and the Plague* – Carlo Cipolla writes about the hunger and destitution that followed in the footsteps of lockdowns and quarantines. This aspect of epidemics has only accelerated, due to what Aberth terms the "third transition" in his *Plagues in World History* – the globalization of disease environments. Huber talks of the increased velocity of transport and communication as an important impetus for the International Sanitary Conventions – these steps towards a standardized approach were a response to the rising perception at the time of "unlimited and borderless space". This "closing in" of the world and with it the risk of disease is especially apparent in *Plague Ports*, as the book takes us around the world with the third bubonic plague: from Hong Kong to then-Bombay, Alexandria and Porto, Buenos Aires and Rio de Janeiro, Honolulu and San Francisco, to Sydney and Cape Town. The "we" in question seem to almost inevitably be: "all of us".

Why, then, are epidemic responses so fractured, localized, and politicized? Because, even if the "we" spans the globe, we seem unwilling to yield the "how" that far. The "how" almost always drives us towards a smaller "we". Here, the incongruity: the matter of survival necessitates a global, universal, transnational reaction. But the *political* and *public* nature of that reaction seems to drive us towards limited, parochial, and fractured responses. The extent of public power needed (residual power? police power? emergency powers?) is only available at much lower levels.

To conquer an epidemic, exceptional public power is needed. In her book on medieval Ragusa (*State of Deference*), commonly listed as the site of the first instance of quarantine, Susan Stuard describes the expanding role of civil agency in securing the health of the city. It was to this end that the Ragusan council set up a hospice outside of the walls of the city. By 1377, the council had taken more drastic steps, first introducing a 32-day forced isolation period and later forbidding the import of wheat, fruit and cloth from locations known to harbor the plague. Historical accounts all confirm that spread of infectious disease could only be combatted by the establishment of public authority with sweeping powers and harsh enforcement mechanisms.

In *Florence under Siege,* Henderson describes the Italian public health ministries and their authority. It was an integrated and sophisticated system predicated on the strength of the Italian city-state. Health officials, backed by guards and other enforcement-mechanisms, instituted a system of forced lockdowns, invasive surveillance and reporting, and quarantine, often running into conflict with the church and with lower levels of government. Cipolla relates the detailed communications between health officials in the Tuscan town of Monte Lupe and authorities in Florence, often asking for more guards in order to enforce the strict public health measures against which the villagers rebelled. Epidemics seem to invite, and indeed demand, the intrusion of public power into what usually lies securely within the private.

There seem to be limits on how far removed authority can be before such intrusions are no longer tolerated. Cipolla writes of the insurrection in Monte Lupo against

the Health Magistry in Florence. Chandavarkar discusses the disobedience and desertion of colonial subjects and officers in response Britain's intrusive public health policies. Cities and towns close their doors to higher authorities, physicians defect, people blatantly flaunt their disregard for health rules. In the US, the recent demonstrations insisting on "opening the economy" bears morbid resemblance to the citizens of Monte Lupo insisting, against the Ministry's orders, to attend mass and a procession of clergy. The event lead to a new flare-up of the plague and many more deaths.

Of course, over time, authorities become better at inducing compliance. And these technologies of governance spread globally. In another testament to the international and transnational impact of infectious disease, history shows us how the public health governance methods developed by the Italian city-states spread to England and across the world. Henderson writes that advisers to the Privy Council in England often looked to Italian Health Boards for guidance on how to combat disease. Gradually, these technologies and institutions were disseminated into British colonies as well. Paul Slack writes that the policies and institutions developed in these contexts proved politically – and legally – seminal. They changed assumptions about the responsibilities – and powers – of government. He continues: "the obligation of governments to act to protect the public when epidemics threaten, even at the price of some limitations on private liberties, is something we now take for granted." But it was once a controversial novelty. As he explains: "most of what we understand by public health, its basic rationale and ideology, was first formulated in the context of the plague." From there, it became transferred and transplanted – and transformed – into particular national and local contexts around the world.

Inevitably, expanded public action threatens to expose both authority's fragilities and its excesses. Fragilities, because epidemics reach the body and the first political question. Excesses, because the threat of fragility invites repression. As much as epidemics present opportunities for the assertion of brute public power, they also illuminate the fragilities of existing systems of authority. In *Plague Ports*, for instance, Echenberg illustrates how the outbreak of plague in mainland China and Hong Kong helped provoke the demise of the Qing dynasty, in part due to the birth of the "revive China society", started by Sun Yet-Sen, a young physician disillusioned by the authorities' seeming inability to protect citizens from the plague. Protests in Wuhan earlier this year echo this experience. This means that epidemics are as much a threat to power as an opportunity to assert it. Which leads to abuses. Indeed, much of the history seems to portray health crises as the scenes of broader political clashes and ongoing power struggles.

The third pandemic of the 1890s coincided with an era of western cultural imperialism, and it showed. Bhandarkar describes in *Epidemics and Ideas* how the outbreak of plague in India led to far-reaching invasive and draconian measures by the colonial officials. He also points toward the relaxation of all such measures once the disease became known as one that only affects the poor and the "natives".

In Rio, the discourse around sanitation and "civilization" was ill-disguised code for "washing out" the Afro-Brazilian population. In Hong Kong, the British used medical control of the plague as one of their arguments for extracting more territory on the

Chinese mainland. Similarly, outbreaks of syphilis have been used to criticize the liberation of women. In *Epidemics and Ideas,* we encounter the following argument published in 1908 in *The Lancet* – arguing that the increased 'freedom' granted to Bagandan women in Uganda had led to the syphilis epidemic:

> "… the freedom enjoyed by women in civilized countries has gradually been won by them as the result of centuries of civilization, during which they have been educated… Women whose female ancestors had been kept under surveillance were not fit to be treated in a similar manner. They were, in effect, merely female animals with strong missions, to whom unrestricted opportunities for gratifying these passions were suddenly afforded."

Epidemics reveal the worst in us. Even after the science was firmly in favor of an international standardized reporting procedure for purposes of preventing cholera, the political implications and the power shifts it demanded proved too high a cost for those participants who had the luxury of making such calls.

And this struggle extends to the scientific and epistemic. Modern science has itself become a site of contestation. Huber describes medical science as a realm of national competition and political nationalism. History seems to confirm that diseases are constructed and defined within the context of power-struggles and oppression. In the Americas, the Spanish settlers' immunity to smallpox (due to exposure back in Europe) was used to argue that God was in favor of the Spanish conquest. False theories about how AIDS gets contracted persisted long after science should have disproven them. The 1890s saw a global clash within western science between older sanitarian traditions and newer bacteriological approaches. Unsurprisingly, sanitarian traditions that allowed for more draconian public health enforcement lasted much longer in the colonies than in Europe.

The narrative in most of these histories also display such distortion: the common narrative that places Western practices of quarantine at the center of the discovery of public health is *also* a politicized one: Paul Slack argues that such innovations really had their origin in the Persian Gulf and the Muslim Mediterranean. Of course, science and knowledge are themselves contested. Paul Farmer points toward the political and geo-political consequences of, for instance, naming certain diseases "tropical". On the one hand, the rise of consensus around modern medicine has reduced this. But it would be naïve to think that current consensus is objective and untainted by power-dynamics. Indeed, perhaps most striking is that the rise of modern medicine seems *not* to have eliminated the use of medicinal advice and public health action from being abused for other, malignant political ends. Paul Farmer makes this point in his book, *Infections and Inequalities* – when we think about our knowledge of disease, we should ask "what is obscured in this way of conceptualizing disease? What is brought into relief?"

I see similar questions playing out in the current debate about the relationships between race and COVID-19 health outcomes in the US. There is a similar tug-of-war about whether body weight is a risk factor for COVID-19. This is a contest about which characteristics are to be included in the "disease profile" and which not, and what such inclusion means, and it is a contest that has far-reaching political and

social impact. Think of the recent accusations of racism in China, for example. The same point has been made about politicians downplaying the danger of COVID-19 or doubting the mortality rate. Which is also not new. Echenberg writes about newspapers in Buenos Aires reporting, in the midst of the outbreak of bubonic plague, that "the disease is of an extraordinary benign character", and that the reports about death rates were "greatly exaggerated".

As much, then, as epidemics demand global co-operation, they also invite conflicts. Conflicts where, as Huber says, the boundaries between disciplines, nations, and cultures are defined. And the outcomes have been unbearably unequal. As the world is scrambling to buy up ventilators, CNN recently reported that South Sudan had a total of four. Four ventilators in a nation of 12 million people. The data from COVID-19 confirms what Paul Farmer has been saying: "patients with poor outcomes – those living in poverty, by and large, with minorities and women overrepresented – ha[ve] them because of barriers to effective care".

This Jean-Jacques Rousseau quotation that Farmer cites is appropriate here:

> "Are you unaware that vast numbers of your fellow men suffer or perish from need of the things that you have to excess, and that you required the explicit and unanimous consent of the whole human race for you to appropriate from the common subsistence anything besides that required for your own?"

But taking the whole human race into account would place the public nature of the "how" unbearably far from our bodies. Or so, at least, we seem to have concluded.

This is the second of two parts of this post with reading recommendations on epidemics, international law, and history. The first part can be found here.

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